

the action of *p*-aminobenzoic acid on milk-suppressed berghel² and knowlesi infections, but the effect is not always complete. Moreover, we have now some evidence that other substances besides *p*-aminobenzoic acid may at times have similar effects on milk-suppressed malaria.—I am, etc.,

Liverpool, 3.

B. G. MAEGRAITH.

REFERENCES

- ¹ Maegraith, B. G., Decgan, T., and Jones, E. S. (1952). *British Medical Journal*, 2, 1382.
² Hawking, F. (1953). *Ibid.*, 1, 1201.

"Smog"

SIR,—The recommendation of the London Local Medical Committee to wear gauze masks during a fog may not be acted on by many people, but it seems likely that a loose plug of cotton-wool in each nostril would act fairly efficiently provided there is no mouth breathing. While possibly neither efficient nor advisable in young children, the value of this method can be tested by anyone using it in their coal cellars for a time and then examining the plugs, when the coal dust will be found limited to the outer parts. If a cleaner test is preferred an attempt may be made to inhale snuff—or even pepper—through them.—I am, etc.,

Ferndown, Dorset.

W. McNAUGHTAN.

SIR,—Apropos the recent minor conflict between the London Local Medical Committee and the Ministry of Health on the subject of the efficacy of a gauze mask as a barrier against the solid particles in "smog," the following personal experience may be of some interest.

Some few weeks ago I decided to shift a quantity of coal, which was blocking the entrance of the coal shed, to the far end of the shed. Before commencing the work I donned a mask, which was of the usual pattern used in operating theatres, in the hope that much of the coal dust would be stopped thereby. To my surprise, at the end of the operation I found that most of the coal dust was deposited on the inner surface and amazingly little on the outer.

The lesson is obvious. The mask, being tied over the bridge of the nose and under the chin, left a wide gap along the upper border through which the coal dust had been aspirated, testimony for which was provided, in this instance, by the liberal coating of coal dust along the alae nasi.

I very much doubt whether such a mask would afford any measure of protection against "smog" particles.—I am, etc.,

St. Helens, Lancs.

L. CRAWFORD.

SIR,—In connexion with the much-discussed problem of "smog," I have met with several patients who have undoubtedly been suffering from varying degrees of carbon-monoxide poisoning. They have been drivers of cars and held up in traffic jams, owing to dense fog. In view of the tragic number of deaths which occurred as a result of the "smog" last winter, every effort should be made to lessen the collection of noxious gases in a motionless atmosphere. One way of doing this would be to switch off motor engines when there is a hold-up of more than a few minutes. It is very simple to switch on again when traffic begins to move.

I personally have suffered nausea and severe headache from petrol and diesel oil fumes when in a traffic block for 20 minutes, irrespective of fog, so how much greater will be the concentration in still air?—I am, etc.,

Chigwell, Essex.

CONSTANCE P. F. THOMAS.

Clinical Pathology in General Practice

SIR,—Dr. A. J. N. Warrack's comments (*Journal*, October 24, p. 935) on my account of the facilities provided for the general practitioner by the Public Health Laboratory Service (*Journal*, October 10, p. 823) should encourage us to think a little more carefully about what we mean by a consultant service in clinical pathology.

Even in the best hospitals, I doubt whether every request for a laboratory examination is preceded or followed by a discussion of the case between the clinician and the pathologist. Occasionally, it is true, the clinician will approach the pathologist to ask for advice before planning his investigation, but such consultations arise more commonly after one or more examinations have been carried out. Indeed, in most cases no such personal consultation takes place, because the results of the laboratory tests have provided the information the clinician requires. The essential elements in the situation are that the clinician should know that he can approach the pathologist when he needs advice, and that the pathologist should seek every opportunity to tender advice when his results suggest that it is needed. There is no reason why the position of the general practitioner in relation to the laboratory should be in any way different from that of the hospital doctor. He, too, should be able to learn when to begin by consulting the pathologist and when to submit specimens first.

Dr. Warrack deplores the division of clinical bacteriology into "infectious" and non-infectious," but this is the way in which the pathological services are divided in the National Health Service. The hospital service deals essentially with the curative, the public health service with the preventive side. In practice the division seldom leads to serious trouble, and most of the apparent anomalies which Dr. Warrack instances can be settled quite easily by the heads of the laboratories concerned. Close co-operation between the two services is essential, but the form it takes must depend on local circumstances. The aim is to site the two laboratories together so that they may work under the same favourable conditions as Dr. Warrack enjoys at Sheffield.—I am, etc.,

Manchester.

M. T. PARKER.

Prolapse of the Urethra in Young Girls

SIR,—May I be permitted a brief comment on the case recorded by Mr. H. H. Fouracre Barns (*Journal*, October 3, p. 765)? I have met with several instances of this lesion over the years.

In the aetiology it should not be forgotten that a urinary infection with transient cystitis and straining may be an important factor, and in the treatment simple conservative measures, if patiently pursued, can, in my experience, prove entirely successful. They should be given an extended trial before any operative interference is resorted to. An account of this somewhat rare condition will be found in *The Urology of Childhood*.¹—I am, etc.,

Deal.

T. TWISTINGTON HIGGINS.

REFERENCE

- ¹ Higgins, T. T., et al. (1951). *The Urology of Childhood*. Butterworth, London.

The Human Foot

SIR,—It was interesting for those of us in the School Health Service to read the two articles (*Journal*, October 3, pp. 745 and 749) and the annotation (p. 772) on foot defects. Such research is perhaps useful corroboration of what is virtually self-evident when the question of shoes and feet is seriously considered. In old China binding of women's feet was accepted without question as a social convention. We still accept it here—for both sexes—admittedly in a lesser degree. It is impossible to buy ready-made shoes which fit the natural shape of the feet except in a few expensive brands for younger children. For adults such shoes do not exist. The inner border of the shoe should be straight. Almost all shoes have a curved inner border, with the result that they act as a permanent splint tending to mould the hallux into a valgus position. It is strange that this obvious fact was omitted from all three papers. It is a fact greatly disliked by the shoe trade and one which they try to conceal as much as possible. It will be time for the real research to begin when it is possible for the population to obtain